South Carolina Department of Insurance

Capital Center
1201 Main Street, Suite 1000
Columbia, South Carolina 29201

Mailing Address:
P. O. Box 100105, Columbia, SC 29202-3105
Telephone: (803) 737-6134

MARK SANFORD
Governor

SCOTT RICHARDSON
Director of Insurance

MEMORANDUM

TO: All Administrators of Insurance Benefit Plans (TPAs)

FROM: Director of Insurance of South Carolina

SUBJECT: Procedures for Continuation of Administrator of Benefit Plans License for the Year Ending 2009

Pursuant to S.C. Code Ann. §38-51-20, attached is the renewal application (Form 1030RN) for the calendar year 2009 for the continuation of your Administrator of Benefit Plans Certificate of License.

Please complete Form 1030RN for calendar year 2009. As a reminder, an officer must sign the report if the administrator is a corporation; all partners must sign if the administrator is a partnership; and if sole proprietorship, the individual proprietor must sign. If necessary, attach additional sheets to identify the plans reported on Section 3, 4 and 5 on Form 1030 RN. The renewal fee is $100.00 (**All fees are non-refundable upon receipt**).

To ensure the application is properly completed, you must comply with the following:

Section 1. Provide a listing of all officers and directors affiliated with the administrator. Attach a biographical affidavit for each officer and director. All biographical affidavits must be signed and notarized. An NAIC biographical affidavit is acceptable. (New biographical affidavits must be filed each year.)

Section II. In accordance with Code Section 38-51-30, please indicate below the type of security pledged to the South Carolina Department of Insurance. Attach a copy of the security pledged to Form 1030RN with the expiration date (if applicable).

☐Surety Bond ☐Certificate of Deposit ☐Letter of Credit ☐Corporate Guaranty

Section III. Provide a list of all administrative/service agreements currently in-force or amended since the last renewal period covering residents of this State. Amended agreements must be attached.

Submit your year-end financial statement. All financial statements must include a Balance Sheet and Income Statement. All financial statements must be signed by the President or an officer of the company and executed before a Notary Public.

Section IV. List all single employer entities, which cover residents of this State. (Attach a separate sheet if necessary).

Section V. List all multiple employers' plans that cover residents of this State. (Attach a separate sheet if necessary).

All reports and related items must be received by March 1, 2010. Any filings received after March 1 may be subject to administrative disciplinary action.

ALL INFORMATION MUST BE PROVIDED. ALL RENEWALS MUST DISCLOSE A CONTACT PERSON AND PHONE NUMBER. ANY REPORT RECEIVED INCOMPETE WILL BE RETURNED.

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APPLICATION FOR RENEWAL OF ADMINISTRATOR OF INSURANCE BENEFIT PLAN FOR THE LICENSING PERIOD 03/01/2010 THROUGH 02/28/2011.

Company Name: _____ Company Code: _____
Mailing Address: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Contact: _____ Web Address: _____ Business Phone No: _____

THE RECORDS OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE REFLECT THAT YOUR ORGANIZATIN IS CURRENTLY LICENSED AS AN ADMINISTRATOR OF INSURANCE BENEFIT PLAN PURSUANT TO THE REQUIREMENT OF S.C. CODE ANN. 38-51-20 (SUP 1997). YOUR CONTINUATION LICEANSE FEE IS $100. PLEASE MAKE YOUR CHECK PAYABLE TO SOUTH CAROLINA DEPARTMENT OF INSURANCE. THIS APPLICATION MUST BE COMPELTED AND RETURNED TO THIS DEPARTMENT ALONG WITH ALL OTHER REQUIRED ITEMS BY 03/01/2010.

SECTION I – LIST ALL OFFICERS AND DIRECTORS (Attach a completed biographical affidavit)

1.
2.
3.
4.

SECTION II – PROVIDE EXPIRATION DATE OF SECURITY PLEDGED

Expiration Date of Surety Bond: _____

SECTION III – LIST ALL INSURANCE COMPANIES WHICH COVER RESIDENTS OF THIS STATE (Attach a separate sheet if necessary)

1.
2.
3.
4.

SECTION IV – LIST ALL SELF INSURED ENTITIES WHICH COVER RESIDENTS OF THIS STATE (Attach a separate sheet if necessary)

1.
2.
3.
4.

SECTION V – LIST ALL MULTIPLE EMPLOYER OR SINGLE EMPLOYER PLANS WHICH COVER RESIDENTS OF THIS STATE (Attach a separate sheet if necessary)

1.
2.
3.
4.

APPLICANT'S SWORN STATEMENT

I do solemnly swear that all information contained within this application is complete, true, and correct to the best of my knowledge. Sworn to before me this _____ day of _____.

Signed _____

Title _____